AETNA CLASS ACTION LUMBAR ARTIFICIAL DISC REPLACEMENT REIMBURSEMENT CLAIM FORM

You are receiving this Claim Form because records indicate you are a Class Member in a consolidated class action lawsuit *Brian Hendricks and Andrew Sagalongos v. Aetna Life Insurance Company*, Case No. 2:19-cv-6840-AB and *Andrew Howard v. Aetna Life Insurance Company*, Case No. 2:22-cv-01505-AB in the U.S. District Court for the Central District of California (the "*Hendricks-Howard* class action").

If Aetna denied your precertification request or post-service claim for single-level lumbar artificial disc replacement surgery (L-ADR) on the ground that L-ADR was "investigational" or "experimental," and you proceeded to pay out of pocket for that surgery, and you were not reimbursed from another source (including, for example, insurance or Medicare), then you may use this claim form to request reimbursement of the amount you paid for the surgery—up to a maximum of $55,000—as part of the settlement of the *Hendricks-Howard* class action.

You must submit a Claim Form by September 29, 2026, to Atticus Administration at the address below. **To receive any payment, you must also include with your Claim Form both of the following:**

(1) Documentation sufficient to show you had a single-level L-ADR, such as an operative report or other clinical records (sufficiently detailed payment records will also suffice if those records show you had a single-level L-ADR); and

(2) Proof of your payment (checks, wire-transfer receipts, invoices reflecting actual payment, or other reasonable proof substantiating payment) showing your net unreimbursed out-of-pocket payments to medical providers for that surgery.

Within 90 days of receiving your Claim Form, the Settlement Administrator will tell you its decision on whether you will be reimbursed. Reimbursement will be for actual, unreimbursed costs. In no event will reimbursement exceed $55,000. **Submitting this form does not guarantee reimbursement.**

For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent reimbursement for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Instructions:

Please read and follow all the instructions in this Claim Form. If you have any questions about this form, or if you need an additional form, contact the Settlement Administrator at 1-800-243-4551. When you have completed this Claim Form, please mail it—along with supporting documentation—directly to the Settlement Administrator at the address listed below:

Hendricks and Howard v Aetna Life Insurance Co.
c/o Atticus Administration
PO Box 64053
Saint Paul, MN 55164
Email: LADRSurgerySettlement@atticusadmin.com

CLASS MEMBER INFORMATION				
Last Name	First Name			Middle Name
Home Address		Date of Birth (Mo / Day / Yr)		Primary Phone Number
City	State	Zip	Patient Sex	Is this a new address? YES ☐ NO ☐
Are you currently enrolled in health coverage through Aetna? YES ☐ NO ☐				
If you checked the "YES" box in the row above, complete the additional rows below in this table.				
Aetna member ID number:				
Is your current Aetna health coverage group health coverage? YES ☐ NO ☐ I DON'T KNOW ☐				
Aetna coverage group name or employer name (if applicable):				
Aetna coverage group number (if applicable):				

CONTINUED ON NEXT PAGE

OTHER COVERAGE OR BENEFITS INFORMATION	
Have you received coverage or benefits from any other health plan or health insurance company for L-ADR? YES ☐ NO ☐	Were you were enrolled in Medicare when you paid out of pocket for L-ADR? If so, indicate the parts you were enrolled in at the time of coverage. If you were not enrolled in Medicare, leave this box blank. PART A ☐ PART B ☐ PART C (also called a Medicare Advantage Plan) ☐
If you checked the "YES" box above, write in this box the date you received coverage or benefits and what dollar amount of benefits you received. Date: Amount:	If you checked any box above, write in this box the effective date of your Medicare coverage and the end date. If you are currently enrolled, write "N/A" for the End Date. Effective Date: End Date:

Name of other health plan or insurance company		Policy No. / Subscriber No.		
Health Plan or Insurance company address	City	State	Zip	
Name of policyholder		Social Security No.	Date of Birth	
Employer Name	Employer Address	City	State	Zip

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AUTHORIZATION TO OBTAIN AND RELEASE MEDICAL INFORMATION

I hereby authorize any physician, health care practitioner, hospital, clinic, or other medically related facility to furnish to Aetna Life Insurance Company, its agents, designees, or representatives, any and all information pertaining to medical treatment for purposes of reviewing, investigating, or evaluating this claim. I also authorize Aetna Life Insurance Company, its agents, designees, or representatives to disclose to a hospital or health care service plan, insurer, or self-insurer any such medical information obtained if such disclosure is necessary to allow the processing of any claim.

This authorization becomes effective immediately and will remain in effect until _____.

A photocopy or scan of this authorization will be considered as effective and valid as the original.

I certify that the above statements are correct.

AETNA MEMBER, FORMER MEMBER, OR PARENT OR LEGAL GUARDIAN'S SIGNATURE (if Member is under 18 years old)	PRINT NAME	DATE

CONTINUED ON NEXT PAGE

INFORMATION ABOUT YOUR L-ADR SURGERY

Complete this table to the best of your ability.

Dates Of Service	Place Of Service	Health Care Provider	Service received	Total charge for the service	Unreimbursed amount you paid for the service
Example June 17, 2019	ABC Hospital	Dr. John Smith	L-ADR surgery at L4-L5	$45,000	$30,000
1.					
2.					
3.					
4.					

Add additional rows on a separate page if necessary.

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(2) Proof of your payment (checks, wire transfer receipts, invoices reflecting actual payment, or other reasonable proof substantiating payment) showing your net unreimbursed out-of-pocket payments to medical providers for that surgery.

You can request from your medical provider your clinical records and bills if you have not kept copies.

The Settlement Administrator cannot process any reimbursement under the Settlement without the information described in paragraphs (1) and (2) on this page.

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CERTIFICATION	
I CERTIFY UNDER PENALTY OF PERJURY THAT I HAVE PROVIDED TRUE AND ACCURATE INFORMATION ON THIS CLAIM FORM AND ACCOMPANYING CLAIM FORM DOCUMENTATION PAGE(S) TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THIS CLAIM IS SUBJECT TO REVIEW AND VERIFICATION, AND THAT THE SETTLEMENT ADMINISTRATOR MAY REQUEST THAT I SUBMIT ADDITIONAL INFORMATION TO SUPPORT MY CLAIM FOR REIMBURSEMENT.	
SIGNATURE OF AETNA MEMBER OR FORMER MEMBER (or signature of parent or legal guardian if Member is under 18 years old): _____	DATE